How Music Therapists Address Spiritual Issues with Clients in End-of-Life Care: An Integrative Literature Review

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ABSTRACT

How Music Therapists Address Spiritual Issues with Clients in End-of-Life Care: An Integrative Literature Review

Jihyun Hong

Although music therapists are often called upon to address spiritual needs and issues of clients in end-of-life care, most have limited education and/or training in this and few resources exist to help guide them in this area of clinical practice. Furthermore, it is important for music therapists to understand the pertinent ethical and professional boundaries. The purpose of this integrative literature review was to synthesize information contained in the music therapy literature in order to describe how music therapists are addressing spiritual issues in end-of-life care. This in turn helped to identify positive aspects of the work, problems that need to be addressed, and possible gaps in services. Twenty-four sources that met the criteria for inclusion were reviewed. Results revealed that music therapists are addressing a range of spiritual needs/issues with their clients in end-of-life care and are using multiple types of interventions to do so. However, the literature also revealed that music therapists experience a number of complex challenges in this work. Although there are some specific and general suggestions on how these challenges may be addressed, the extent to which music therapists are following through on these suggestions is unknown. Reflections upon the results and limitations of the research as well as potential implications for practice, research, and training/education are presented.

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Table of Contents

List of Tables

Chapter 1. Introduction

Significance of the Inquiry

Addressing the spiritual needs of clients who are in end-of-life care is recognized as an important part of healthcare professionals' practice. When spiritual needs are met, clients may experience new joy for life, relief from pain, and feelings of peace (Renz, Mao, & Cerny, 2005). If spiritual needs are ignored, spiritual suffering may occur and clients may question life's meaning, feel abandoned by God, and/or experience difficult emotions such as feelings of anger towards a higher power (Nelson-Becker, Ai, Hopp, McCormick, Schlueter, & Camp, 2015).

Addressing issues related to spirituality can be an integral part of clients' experiences in music therapy since music has the ability to impact meaningful change (Potvin & Argue, 2014). Furthermore, given that music is often linked with a range of spiritual practices (Magill, 2005; Potvin & Argue, 2014) and/or can evoke experiences that may be described as spiritual (Abrams, 2001), music therapists often find themselves in the position of addressing spiritual issues with their end-of-life care clients. Literature indicates that spiritual support provided within music therapy sessions can have positive impacts for clients. These include improvement in mood and ability to relax, decrease in depression and suicidal thoughts (Wlodarczyk, 2007), feeling closer to a higher power, and experiencing feelings of reassurance, faith, creative transformation, and/or transcendence (Belgrave, Darrow, Walworth, & Wlodarczyk, 2011; Krout, 2001). In addition, by engaging family members or loved ones in a shared music experience with a client, the music therapist may be able to facilitate emotional connections among them (Clements-Cortes, 2013).

The literature also indicates, however, that music therapists can face challenges when addressing the spiritual needs of persons in end-of-life care. For example, if not acknowledged and carefully monitored, music therapists' personal beliefs and morals can inadvertently impact their work, especially with clients whose spiritual practices or beliefs differ from their own or with clients who come from different cultural backgrounds or have significantly different lifestyles (Potvin, 2013). Furthermore, there seems to be a lack of clear guidance around how spiritual care practices should be conceptualized within the field of music therapy (Masko, 2016).

Much in the same way that it is important for other healthcare professionals to understand the boundaries around the use of music in their practices, (i.e., what practices can and cannot be

done by a healthcare professional who is not a credentialed music therapist), music therapists also need to understand boundaries around the spiritual care practices they are implementing with end-of-life clients. For example, at what point should a music therapist collaborate with or refer to a credentialed spiritual care practitioner? Kirkland and McIlveen (2000) outline a collaborative approach they developed using music therapy and spiritual care for elderly persons with various cognitive challenges. They provide examples on how to facilitate individual and group sessions that focus on various spiritual themes that are explored through music and other creative mediums/techniques. However, their approach does not address scope of practice per se and end-of-life care (as defined in this thesis; see Key Terms on p. 4) is not directly addressed. The American Music Therapy Association's (AMTA) Standards of Clinical Practice (2015) includes determining clients' religion/spirituality as a standard part of the music therapy assessment process. This document also indicates that music therapists should maintain their "knowledge of current developments in research, theory, and techniques in music therapy in issues involved in death and dying, grief, loss, and spirituality" (Standard VII - continuing education, Para. 1). The Canadian Association of Music Therapists (CAMT) is currently developing a Scope of Practice document that is not yet available to music therapists (L. Young, personal communication, July 26, 2016). The AMTA Professional Competencies (2013) and the CAMT Recommended Competency Areas documents (Canadian Association of Music Therapists, n.d.) do not directly address the topic of spirituality. The AMTA Professional Advanced Competencies document (2007) indicates that music therapists should "demonstrate understanding of the importance of personal reflection [in] spiritual pursuits" (Personal Development, Para. 1). The personal development section advises the music therapist to "develop self awareness and insight through personal experiences in music therapy" (Personal Development, Para. 1), which is relevant as music therapists should maintain a high level of personal awareness when addressing spiritual issues with their clients. Within the multicultural development section, the AMTA advanced competencies document indicates that music therapists "demonstrate knowledge of and respect for diverse cultural backgrounds [and] how music therapy is practiced in other cultures" (Multicultural Development, Para. 1). This may refer to spiritual issues that the music therapist might encounter when working with diverse clients who have a variety of backgrounds and beliefs. The CAMT Advanced Competencies document (n.d.) does not directly refer to spirituality, although a recommendation for "diligent

sensitivity regarding the implications of cultural influences" could be applicable to this subject area (Multicultural issues, Para.1). Given the lack of clarity and specificity around spiritual care practices in music therapy, it appears that music therapists could benefit from having more guidance in this area.

My experiences during music therapy internship and practicums (pre-professional and advanced) motivated my initial interest in this topic. While working in palliative care and oncology, I met clients who explicitly or implicitly indicated a need for spiritual support during our sessions. For example, some clients asked for hymns that reflected their religious beliefs such as *"Just as I Am," "Jesus Loves Me,"* and *"The Lord is My Shepherd."* Others requested songs not necessarily affiliated with any religion that contained messages of hope, trust and/or belief in a higher power such as *"You Raise Me Up"* and *"You Light Up My Life."* Family members also requested hymns such as *"How Great Thou Art"* or other inspirational/secular selections such as *"Moon River"* when their loved ones were experiencing pain or discomfort, perhaps hoping that this music would offer some relief. There were other instances when clients seemed to imply a possible desire for spiritual support by the items displayed in their rooms. For example, some of my clients displayed pictures of Mother Mary or Jesus. In these instances, I would take steps to further determine the individual's religious background and personal preferences (e.g., consult their chart, ask the client, etc.) and provide subsequent support, for example, singing Catholic hymns or improvising vocally using the melody of "Ave Maria." There were instances where the client's room was covered with photographs of family members and nature. In these cases, I would ask clients about meaning of the photos and provide preferred music that contained related themes. I began to realize the multi-faceted complexities of addressing my clients' spiritual needs, especially in light of my own Christian beliefs which were not always the same as my clients' beliefs. I wondered what my professional boundaries should be and was curious as to how other music therapists addressed these issues. In reviewing the literature, I realized that although there is a growing amount of information on music therapy and end-of-life care, the answers to my questions were not adequately or directly addressed in any one of these writings and that further contemplation and investigation would be required.

Statement of Purpose

Despite a growing body of literature on music therapy and end-of-life care, music therapists need further clarity and guidance on how spiritual issues should be addressed in

practice. The purpose of the study was to synthesize the information contained in the music therapy literature on this topic. Specifically, I reviewed and organized existing information in order to more comprehensively describe how music therapists are addressing spiritual issues in end-of-life care, which in turn helped to identify positive aspects of the work, problems that need to be addressed, and possible gaps in current services. It was my hope that this holistic conceptualization will help music therapists gain new understandings in this area of practice, which in turn will improve the quality of care being provided and indicate directions for moving forward.

Research Questions

The primary research question was: How do music therapists address spiritual issues with clients in end-of-life care? Subsidiary research questions were: (a) What spiritual issues/needs are music therapists addressing with their clients in end-of-life care? (b) What interventions are music therapists using to address these issues/needs? (c) What (if any) challenges do music therapists experience in addressing issues/needs related to spirituality in end-of-life care? (d) Do music therapists address these challenges and if so, how?

Key Terms

"Spirituality is an aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred." (Puchalski, et al., 2009, p. 887).

"End-of-life care refers to care for people in decline who are deemed to be terminal or dying in the foreseeable (near) future" (Canadian Institute for Health Information, 2011, p. xii). Within the context of this paper, end-of-life care is used to refer to care provided to those living with a terminal illness, from the time they are classified as palliative up to and including the time of death.

Music therapy within the context of end-of-life care is defined as "the creative and professionally informed use of music in a therapeutic relationship with people who are living with life-threatening illnesses, and their close family and friends" (O'Callaghan, Forrest, & Wen, 2014, p. 470).

Music therapy interventions are being defined as music experiences that encompass clients (and their loved ones when applicable), process, product, and context and are used as

agents, media, and outcomes for change (Bruscia, 2014). Bruscia has identified four main categories of music experience: receptive, re-creative, improvisational, and, compositional. Interventions identified in this study have been organized according to these categories.

Chapter Summary

This research has been organized into four chapters. Chapter One describes the significance and purpose of the inquiry. Research questions are presented and key terms are defined. Chapter Two describes the rationale for the integrative literature review methodology utilized in this research as well as the data collection and analysis procedures. Chapter Three presents the results of the review, which are organized according to the subsidiary research questions. Chapter Four presents some reflections upon the results as well as limitations of the study. Implications for practice, research, and education are also discussed.

Chapter 2. Methodology

Design

This research employed an integrative literature review design. "The integrative literature review synthesizes representative literature on a topic in an integrated way such that new frameworks and perspectives on the topics are generated" (Torracco, 2011, p.356). As indicated in Chapter One, in spite of a growing amount of literature on music therapy and end-of-life care, music therapists need clarification around how spiritual issues should be addressed within the context of their clinical work. As no literature review on this topic has yet been conducted, I felt that music therapists (including myself) could "benefit from a holistic conceptualization and synthesis of the literature to date" (Torracco, 2011, p. 357). This would not only provide much needed clinical guidance, but also potentially identify gaps or problems in the way that services are currently being provided and indicate further areas for research.

In order to focus the scope of the current study and to fit it within the timeline of a Master's thesis, some delimitations were imposed. Although other health professionals may include music and spiritual practices in their work, I only reviewed literature that referred to spiritual issues that credentialed music therapists are addressing with their clients in end-of-life care contexts and/or how they are addressing them. Although families/loved ones are often included in sessions, they were not considered as clients within the context of this study and therefore information related to how music therapists work with these individuals was not included. The data was delimited to material published between 2005 and April 2016. This included peer-reviewed journal articles and book chapters (English only). Relevant unpublished Masters theses and PhD dissertations from the same time period were also reviewed.

Data Collection Procedures

I conducted an electronic key word search of 8 databases. These included: ERIC, MEDLINE, PsycINFO, RILM Abstracts of Music Literature, SocINDEX, Religion and Philosophy Collection, ATLA Catholic Periodical and Literature Index, and ALTA Religion Database with ATLASerials. Search terms included 'music therapy' AND 'palliative care' or 'music therapy' AND 'end-of-life' placed in the top search box. These terms were then combined with the terms 'spiritual care,' 'spiritual needs,' or 'spirituality' in the secondary

search box. I also reviewed the reference lists of literature that I found and tried to locate electronic or hard copies of any relevant articles, chapters, documents, and/or books.

A total of 24 sources from the literature (that met inclusion criteria as outlined above) were reviewed for this research project. This included 13 peer reviewed journal articles, nine book chapters, one master's thesis, and one doctoral dissertation. See Table 1 below.

Table 1

Publications Reviewed

Author	Year of Publication	Type of Report	Name of Source
Renz,M Mao, M., & Cerny	2005	Journal Article	*American Journal of Hospice & Palliative Medicine*
Dileo,C &Magill, L.A.	2005	Book Chapter	*Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and studetns*
Magill, L.	2005	Book Chapter	*Music therapy at the end-of-life*
Scheiby, B.B.	2005	Book Chapter	*Music Therapy at the end-of-life*
Dileo,C., & Starr, R.	2005	Book Chapter	*Music Therapy at the end-of-life*
Nakkach, S.	2005	Book Chapter	*Music Therapy at the end-of-life*
Hillard, R.E.	2005	Journal Article	*Evidence-Based Complementary and Alternative Medicine*
Zabin, A.H.	2005	Journal Article	*Music Therapy Perspectives*
Magill, L.	2006	Book Chapter	*Music and altered states: Consciousness, transcendence, therapy and addictions*
Aldridge, D.	2007	Book Chapter	*Whole person healthcare Vol 3: The arts and health*
Houck, A.J.W.	2007	Dissertation	*The development of a music therapy protocol for determining the spiritual needs of hospice clients*
Wlodarczyk, N.	2007	Journal Article	*Journal of Music Therapy*
Cardin, M.L.	2009	Journal Article	*Voices: A World Forum for Music Therapy*
Clements-Cortes, A.	2010	Journal Article	*Canadian Journal of Music Therapy*
Pawuk, L.G., & Schumacher, J.E.	2010	Journal Article	*Home Healthcare Nurse*
Squires, K.	2011	Master's Thesis	*Staff perceptions of how music therapy can support palliative care clients in a New Zealand/Aoteroa hospice, with particular focus on spiritual care*
Belgrave, M., Darrow, A., Walworth, D., & Wlodarczyk, N.	2011	Book Chapter	*Music therapy and geriatric populations: A handbook for practicing music therapists and healthcare professionals*
Barton,M., & Watson, T.	2013	Journal Article	*British Journal of Music Therapy*
Clements-Cortes, A.	2013	Book Chapter	*Guidelines for music therapy practice in adult medical care*
Cook, E.L., & Silverman, M.J.	2013	Journal Article	*The Arts in Psychotherapy*
Kidwell, M.D.	2014	Journal Article	*Music Therapy Perspectives*
Potvin, N.	2015	Journal Article	*Music Therapy Perspectives*
Renz, M., et al.	2015	Journal Article	*American Journal of Hospice & Palliative Medicine*
Neudorfer, A.	2016	Journal Article	*Approaches: An Interdisciplinary Journal of Music Therapy*

Data Analysis Procedures

I carefully reviewed all of the material, re-reading it several times in order to extract all relevant information. I then organized this information using the four subsidiary research questions as overarching categories. Under the first category, spiritual needs/issues were organized into emergent subcategories. In the second category, music therapy interventions used by music therapists in end-of-life care to address spiritual needs/issues were organized according to music experiences (i.e., interventions) as defined by Bruscia (2014). In the third category, challenges that music therapists experienced when addressing needs/issues in end-of-life care contexts were organized into emergent subcategories. Ways in which these challenges are addressed were incorporated into the subcategories if such information was provided. These procedures allowed me to assess how well the topic was represented in the literature, which is discussed in Chapter Four.

In conducting this study, I also considered issues related to trustworthiness of the findings. Credibility of the results was assured through engaging with the data over time and through reflecting upon this information and making connections to my pre-professional and advanced internship/practicum experiences in end-of-life care contexts. I had ongoing consultations with my thesis adviser, which helped me to maintain conscious awareness of my personal beliefs, biases and/or assumptions. This helped me to keep these issues in check and/or acknowledge how they were influencing the research process. My ability to be reflexive was further ensured by reading literature that pertained to spiritual practices that fall outside of my own Christian faith, such as Bregman's (2010) book about bereavement and death rituals. Regular consultations with my thesis adviser also helped to ensure dependability of the findings, verifying that the results and my interpretations are supported by the data.

Chapter 3. Results

As noted in Chapter Two, information extracted from relevant literature was organized using the first three subsidiary research questions (see p. 4) as overarching categories. Information pertaining to the fourth subsidiary question was integrated into the third overarching category. Further details on whether subcategories emerged or were predetermined are included under each of the three overarching categories presented in this chapter.

Category One: Spiritual Issues or Needs Addressed by Music Therapists

As noted in Chapter One, "spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski, et al., 2009, p. 887). Spiritual needs/issues addressed by music therapists (as outlined in the literature that I reviewed) were guided by this definition and organized into seven emergent subcategories. These subcategories are not presented in any particular order.

Subcategory one: Need to transcend one's current situation. Several articles indicated that music therapy in end-of-life care can help to facilitate or activate a vital process of transcendence for clients (Neudorfer, 2016). In the face of loss, clients need to move beyond the situation and beyond the suffering of body and mind in order to cope, obtain a sense of calm, peace, and/or comfort, feel love, feel soothed, and gain deeper understanding (Magill, 2006; Squires, 2011). Music therapy can facilitate a process of transcendence by penetrating cognitive and affective domains (Magill, 2005). During music therapy sessions, clients reported feeling in touch with nature and becoming conscious of their inner spiritual essence (Magill, 2006). They are able to forget that they are sick and go to another place through the music (Squires, 2011).

Subcategory two: Need to find meaning. End-of-life care clients are faced with existential questions where they search for meaning and purpose in what is happening to them in the here and now (e.g., their illness) as well as in the lives that they have lived up to this point. Music therapy interventions can help individuals to review their lives and recall memories, which can help in their search for meaning and restore their sense of hope and purpose (Magill, 2006; Neudorfer, 2016; Squires, 2011) as well as lead to growth and healing (Houck, 2007). For example, with a patient who was experiencing loss in meaning and purpose in life, the music

therapist presented songs that contained themes related to questions and wonderings about life. Through these songs, the patient was able to talk about his feelings, converse more openly with other hospital staff, and made a recording for his brother. Through music therapy, he was able to access his repressed thoughts and feelings and open himself to others, which resulted in "a renewed sense of meaning in his life" (Magill, 2005, p.15).

Subcategory three: Need to restore or affirm one's sense of hope and faith. When nearing the end of one's life, some individuals may experience feelings of hopelessness and lose their sense of faith (i.e., their belief in a higher power or purpose that is greater than one's self; Magill, 2005). However, faith and hope can alleviate suffering and provide individuals with ways of "coping with loss, demise and personal demoralization" (Magill, 2006, p.175). Music therapy can provide comfort and reassurance to end-of-life care clients and help them connect with their faith (Houck, 2007). In cases where clients relate music to the Divine or a higher power, music can enhance their sense of faith, "providing the means for petition, prayer and praise" (Magill, 2006, p.175). Clients' comfort and hope can be inspired by the creativity inherent in music (Magill, 2005) and they can experience a restored "sense of purpose, wholeness, and hope" (Houck, 2007, p.35). When individuals are experiencing distress, despair, and anguish, even those who are not particularly religious may call out to a higher power with a prayer, and music can add a voice to support and/or validate their emotions and prayers (Magill, 2005).

Subcategory four: Loss of spiritual/personal connection with others. In addition to losing their sense of faith, some end-of-life care clients can also feel a loss of spiritual and/or personal connection with others. For various reasons, they can become isolated from their spiritual community, which can result in "spiritual distress, loneliness, and depression" (Belgrave, Darrow, Walworth, & Wlodarczyk, 2011, p.77). Clients often suffer from the lack of spiritual connection and spiritual based rituals in end-of-life care environments (Cook & Silverman, 2013; Hilliard, 2005). Aldridge (2007) notes that many of the terminally-ill AIDS clients with whom he worked suffered from loss of personal relationships and experienced isolation. In these cases, music therapists may establish meaningful relationships with clients through the creative medium of music. The literature also indicates that music therapists sometimes provide spiritual support for clients who had attended spiritual services prior to their diagnosis (Belgrave, Darrow, Walworth, & Wlodarczyk, 2011). Furthermore, group music

therapy sessions can facilitate spiritual connections with others where clients support one another through musical and interpersonal interactions which increase feelings of social involvement and connection (Clements-Cortes, 2013).

Subcategory five: Loss of identity and lack of connection to sense of self. The literature also indicates that people with a terminal illness often suffer from a loss of "self-esteem, self-identity, and sense of connectedness with self and others" (Magill, 2006, p.177; Neudorfer, 2016). Their illness may also result in the loss of their personal and professional identities in their societal and familial roles (Magill, 2005). Magill (2005) observed that when clients are facing the end-of-life, they often go back to their past memories to find comfort and address unfinished businesses. This not only helps them to understand their life's purpose (as indicated above in subcategory two) but also helps them to reestablish their sense of identity. Here, music can work as a bridge for communication between "the self, to others and to the eternal" (Magill, 2005, p.6) and helps with one's "sense of self-identity and a sense of relatedness" (Magill, 2006, p.178). Also, at the end-of-life, patients can explore new identities with music's malleable qualities that allow the expression of their identities, such as "evoking intrapsychic emotional content, attuning to their expressive needs, and creating container safe for experiencing that content in a meaningful way" (Potvin, 2015, p.56).

Subcategory six: Need for resolution or closure. As death approaches, end-of-life care clients often express concerns about strained relationships, regrets, and/or other unfinished personal business that need to be resolved. Music therapy offers clients and families an expressive forum within which complex feelings can be shared and relationship completion can occur (Magill, 2005; Clements-Cortes, 2010). For example, through interventions that will be further described below (e.g., music improvisation, the Bonny Method of Guided Imagery and Music (BMGIM), live musicking of pre-composed songs, etc.), clients can experience resolution of hurtful and painful emotions (Clements-Cortes, 2013; Potvin, 2015). Difficult emotions such as anger and guilt can be replaced with feelings of resolution and forgiveness (Cadrin, 2009; Clements-Cortes, 2010).

Subcategory seven: Feelings of anxiety, worry, fear and denial. End-of-life care clients can suffer from a wide range of worries, anxiety, and fears which can be further exacerbated by a loss of control (Magill, 2005). Music can calm and soothe as well as evoke comforting images and memories. Music can be a medium to express complex emotions that do

not translate easily in words. Rhythm, harmonic composition, and form can provide clients with feelings of structure and security within the end-of-life care context (Houck, 2007). With the aesthetic beauty of music provided within a secure therapeutic relationship, clients can experience feelings of pleasure, relaxation, peace, serenity, and calmness (Magill, 2005; 2006). In Bonny Method of Guided Imagery and Music (BMGIM) sessions, clients can express their fear of death and find relief and safety through images that may serve as a personal resource (Cardin, 2009). The concept of death is difficult for some clients and some may experience denial and/or refuse to talk about it. Music improvisation may provide some clients with a non-verbal way to express difficult feelings/topics, which can relieve tension and facilitate insight (Clements-Cortes, 2013).

Category Two: Music Therapy Interventions Used to Address Spiritual Issues or Needs

As noted previously, music therapy interventions used by music therapists in end-of-life care to address spiritual needs/issues were organized according to music experiences as defined by Bruscia (2014): receptive, re-creative, improvisatory, and compositional. Within these predetermined subcategories, I created descriptions of all relevant interventions (i.e., music experiences) that I found in the literature. These categories, subcategories, and interventions are not presented in any particular order.

Subcategory one: Receptive music experiences. Receptive music experiences are those in which the client listens to live or recorded music provided by the therapist, the client, or commercial artists and responds to the music "silently, verbally, or in another modality" (Bruscia, 2014, p. 134). In reviewing the literature, I found eight receptive music experiences that music therapists are using to address spiritual issues/needs (as outlined above) in end-of-life care contexts.

Intervention one: Music entrainment. Music entrainment is the "use of vibrations, sounds, and music in various elemental and combined forms to establish synchronicity in autonomic or voluntary body responses: between the client and music, within parts of the client's body, and between the client and another person" (Bruscia, 2014, p. 135). To address spiritual needs/issues in end-of life care contexts, music therapists use entrainment to facilitate connection. For example, the music therapist may adapt the pace of the music to synchronize with the client's rate of breathing and may also breathe with the client. This may help the client

to feel connected to him/herself, the music, and/or the therapist, which in turn can also help the client to feel more comfortable in sharing his/her thoughts, memories, and/or feelings (Kidwell, 2014; Neudorfer, 2016).

Intervention two: Musical life review. Musical life review is defined as "a client creating a list of songs that tells their story, either prearranged or composed by him/herself or the therapist" (Clements-Cortes, 2013, p.302). As such, this intervention could also fall under Subcategory four (Compositional music experiences). It was included here as it appears that in most scenarios, clients are responding to recorded/live pre-composed music within the context of this intervention. In end-of-life care contexts, music therapists use musical life review to help clients find meaning and/or transcend their current life situation. For example, the music therapist might sing and play songs that a client chooses and use these as a stimulus for discussion or framework for life review (Kidwell, 2014; Wlodarczyk, 2007). To facilitate connection to self and others, the music therapist might facilitate what Belgrave, Darrow, Walworth, & Wlodarczyk (2011) refer to as a "spiritual footprint" (p.106) intervention where important life events are discussed such as baptisms, confirmations, weddings, and funerals and appropriate music can be compiled to represent each event. This music can then be recorded in audio or video and shared with loved ones. In another approach to musical life review, the music therapist asks the client to describe his/her life story in five sentences. Then, the music therapist offers relevant song choices to help the client find those that best represent emotional content of her/his life journey. Life review discussion is integrated throughout the duration of the intervention with the music therapist taking the lead as needed by asking questions (Clements-Cortes, 2013). Finally, in end-of-life care contexts, music therapists use musical life review to address the need for relationship closure. Here, music therapists help clients to identify music that is associated with significant people in their lives and "bring resolution and closure to their lives and relationships" (Pawuk & Schumacher, 2010, p.41).

Intervention three: Chanting for the patient. In this context, chanting is defined as the music therapist singing a phrase or words repeatedly in a singsong tone for the client to address feelings of anxiety, worry, and fear. For example, Magill (2006) sang a chant containing the lyrics based on a theme of peace for a client who was experiencing pain and agitation. She used tempo and dynamics to communicate the sense of peace. Music therapists can also invite a client to find a word or group of words that are meaningful, which can be a mantra. The client can

choose "a special word, a thought, a prayer, a meaningful image, a personal testimony, a request, or a message for loved one or for the universe" (Dileo & Magill, 2005, p.238). Having this choice can facilitate a sense of control. Some music therapists may use an Indian chant form, mantra, or Gregorian chant with a repetitive pattern and a drone (Dileo & Magill, 2005; Nakkach, 2005). If the client participates in the chanting, this intervention can also fall under the re-creative and/or improvisatory music experience subcategories as defined below.

Intervention four: Music and imagery. In end-of-life care contexts, music and imagery is defined as the therapist using music to elicit imagery to relax clients and reduce feelings of anxiety, worry, and fear. For example, Houck (2007) presents the case of a hospice client where the music therapist asked the client and her husband to become aware of their breathing and then to describe and subsequently imagine a favorite destination which brought them peace and happiness. While imagining this place, the therapist improvised keyboard music, which supported the essence of their description and matched the pace of the client's breathing.

The Bonny Method of Guided Imagery and Music (BMGIM) falls within this intervention category but is different than music and imagery as described above as it is not about relaxation per se but rather it is "a music-assisted therapy used to explore one's own inner world and help clients to work on significant life issues, for instance, disturbing old memories, losses, trauma, bothering health conditions, and relationship issues" (Training in the Bonny Guided Method of Imagery, n.d., What is GIM?, Para 1.). It is important to note that therapists who use BMGIM must receive specialized training in this method. In end-of-life care contexts, music therapists use the BMGIM to address relationship closure or resolution, to help clients find meaning, and address feelings of anxiety, worry, and/or fear. For example, in a case study presented by Cadrin (2009), the music therapist used the BMGIM to address issues related to fear and anger as well as to help resolve issues related to a difficult relationship that she had with her mother. The client also wrote poems in response to her BMGIM experiences and these creative expressions were also an important part of her therapeutic process. For hospice clients, BMGIM can give the client an opportunity to explore their inner world and imagination at a time when their conscious world is constantly changing and hard to understand (Houck, 2007).

Intervention five: Music listening for relaxation. In end-of-life care contexts, music therapists use music listening to promote feelings of relaxation and reduce feelings of anxiety, worry, and fear. For example, the music therapist can remove distractions and use either live or

recorded music with various verbal relaxation inductions. The music therapist may use clients' preferred genre of music. Music with a 3/4 time signature is recommended for relaxation, and the therapist can play music softly and slowly in a steady tempo with simple chord progression. This can be followed by verbal processing about changes that occurred during the music and awareness of what is happening in the present (Clements-Cortes, 2013). Hock (2007) presents the case of a hospice patient with whom the progressive relaxation was used with music. The music therapist asked the clients to focus on tensing specific muscle groups and then release when exhaling. The music therapist slowed down the tempo of the music to reduce the respiration rate of the client. In a particular example, to address patients' anxiety, anger, and thoughts of suicide, the music therapist implemented progressive muscle relaxation while playing the lyre (Renz, Mao, & Cerny, 2005). Lastly, in a study by Renz, Mao, Omlin, Bueche, Cerny, and Strasser (2015) that examined advanced cancer patients' spiritual experiences of transcendence, the authors identified an example where the music therapist's use of music-mediated relaxation helped alleviate the patient's fear of death.

Intervention six: Music listening to support prayer or worship. In end-of-life care contexts, music therapists use music to support prayer or worship which in turn can help to address the client's need to transcend his/her current situation and/or the need to find meaning. For example, Wlodarczyk (2007) describes the use of client chosen songs to create a sacred space. The creation of such a "space" can bring spiritual issues into clients' conscious awareness thereby facilitating exploration for these issues (Belgrave, Darrow, Walworth, & Wlodarczyk, 2011). Wlodarczyk (2007) also suggests that music therapists may want to team up with a pastoral care professional to offer this service as an interdisciplinary initiative (Wlodarczyk, 2007). Lastly, Houck (2007) presents an example in which the music therapist played supportive religious music as the client's husband performed religious rituals of anointing his wife with holy water as she neared the end of her life.

Intervention seven: Lyric analysis of songs that contain spiritual themes. In end-of-life care contexts, music therapists use lyric analysis of songs that contain spiritual themes to help them find meaning which in turn may help them to address clients' feelings of anxiety, worry, and fear. After identifying the client's preferred spiritual music and subsequently listening to live or recorded versions of this music with the client, the music therapist can facilitate a discussion

with the client about lyrics that resonate with him/her. This may help the client to identify areas of spiritual strength and/or distress (Belgrave, Darrow, Walworth & Wlodarczyk, 2011).

Intervention eight: Song choice. Song choice is defined as the music therapist encouraging "the client to choose and listen to preferred songs" (Clements-Cortes, 2013, p.301). In end-of-life care contexts, music therapists use song choice to address need to restore sense of hope and faith and help them to find meaning. For example, after asking a client to choose a song or identify music that is relevant to her/his life, the client and the therapist then listen to the music together. The music therapist then may facilitate a discussion that explores that music's relevance in the client's life or other therapeutic issues (Clements-Cortes, 2013). Songs that are meaningful for the clients can facilitate a restored sense of hope and faith (Kidwell, 2014; Houck, 2007; Cook, 2013).

Subcategory two: Re-creative music experiences. Re-creative music experiences are those where pre-composed songs or any kind of musical form is being reproduced, learned, sung, played, or performed by the client (Brusica, 2014). In reviewing the literature, I found two re-creative music experiences that music therapists are using to address spiritual issues/needs (as outlined above) in end-of-life care contexts.

Intervention one: Vocal-recreation. Vocal-re-creation is defined as clients being actively involved in "vocal reproduction of structured musical materials or pre-composed songs" (Bruscia, 2014, p.133). In end-of-life care contexts, music therapists may use vocal-re-creation to restore the clients' sense of hope and faith. For example, Magill (2005) describes her work with a client who had difficulty with her faith; she and the client sang hymns that were meaningful for the client and approached the client with compassion and empathy, which in turn renewed the client's sense of hope and faith. In a case study presented by Kidwell (2014), the music therapist and the client also sang hymns together. At one point, the music therapist redirected the client to a different hymn when the patient became quite agitated. The music therapist hummed the new selection to soothe the patient. Scheiby (2005) provides an example where a group of clients were discussing their loss of faith and how singing the song, "I Believe," seemed to help to restore a sense of faith for these clients.

To address loss of identity and connection to sense of self, Clements-Cortes (2013) identifies procedures for helping the client to tone (as described above under receptive

experiences). Here, the music therapist may give the client one tone usually using an open vowel and ask the client to vocalize that tone. The music therapist may assist the client to experiment with more tones.

When introducing songs that the client prefers, the therapist may support the client to sing a solo part. For example, in a case study presented by Kidwell (2014), the music therapist played spiritual selections that the client requested, but gave opportunity for the client to sing some parts on her own (Kidwell, 2014). In other instances, therapists may support clients by encouraging them to lead the tempo of a song or sing a song in his/her own unique style. By giving some control of the session to clients and encouraging self- expression through vocal-recreation, clients may feel a sense of stability and feel able to process unfinished business and/or address regrets (Magill, 2005; Dileo & Starr, 2005).

To facilitate spiritual/personal connection with others, music therapists may lead a sing along with family and friends (Wlodarczyk, 2007). Singing favorite spiritual/other music promotes socialization and the sense of belonging through "choosing, hearing, and participating"(Magill, 2006, p.178; Belgrave, Darrow, Walworth, & Wlodarczyk, 2011). In a case study presented by Magill (2006), singing the song “Danny Boy” brought a mother (client) and son closer together as it had been a song that they used to sing together in the past.

Intervention two: Music performance. Music performance is when “the client plays or sings a composition for others to hear, formally or informally, for small or large audience" (Bruscia, 2014, p.133). In end-of-life care contexts, music therapists may use music performance to help clients address loss of identity and connection to sense of self. In an example provided by Magill (2005), an end-of-life care client who was also a musician chose to perform and record music that expressed themes of love and friendship. He shared this music with other patients, which helped to strengthen/affirm his self-identity as a singer-song writer and an actor (Magill, 2005).

Subcategory three: Improvisational music experiences. Improvisational music experiences are those in which the client uses any musical medium within their own capabilities to make up music by singing, playing, and/or creating that music (Bruscia, 2014). In reviewing the literature, I found three improvisational music experiences (interventions) that music therapists use to address spiritual issues/needs (as outlined above) in end-of-life care contexts.

Intervention one: Instrumental improvisation. In instrumental improvisation, clients use instruments of any kind to make up music on the spot. In end-of-life care contexts, music therapists use instrumental improvisation to create a spiritual environment and address feelings of anxiety, worry, and fear. For example, Belgrave, Darrow, Walworth, & Wlodarczyk (2011) suggest that a sacred space can be created by using instruments such as ocean drums, thunder tubes, rain sticks, etc. that create nature sounds. Music therapists can add support using improvised guitar and/or keyboard music. This activity can lead into or set the scene for clients' "relaxation, meditation, or prayer time" (Belgrave, Darrow, Walworth, & Wlodarczyk, 2011, p.104). In a case described by Scheiby (2005), a man in the end stage of progressive multiple sclerosis improvised music in what she calls "Musical Analytical Meditation" (p.187), using Tibetan bells and a sound bowl to address and calm his inner chaos and conflicts.

In order to address loss of identity and connection to sense of self and need to transcend one's current situation, music therapists can use referential improvisation. Here the client can identify a theme or the therapist can provide one and the client improvises with instruments that are meant to represent or relate to that theme. Referents can include a picture, an emotion (such as fear, strength, sadness, hope or loss), or a personal issue, such as progression of their illness (Clements-Cortes, 2013).

Intervention two: Mixed-media improvisation. In mixed-media improvisation, "the client improvises using voice, body sounds, instruments, and/or any combination of sound sources" (Bruscia, 2014, p.131). In end-of-life care contexts, music therapists use mixed-media improvisation to address clients' needs to restore a sense of hope and faith. For example, in a case study presented by Scheiby (2005), the music therapist implemented improvisation while singing and drumming. This led to a group conversation of existential issues, sharing of anger, and discussion about spiritual support and faith. Mixed media improvisations can also be referential as described above.

Intervention three: Empathic improvisation. In empathic improvisation, a "therapist creates an improvisation that compassionately complements the client's current state of physical and mental being" (Clements-Cortes, 2013, p.301). In end-of-life care contexts, music therapists use empathic improvisation to address loss of spiritual/personal connection with self and others and to facilitate the clients' understanding of their own emotions. Here, music therapists observe the client carefully and note "body posture, facial expression and attitude" (Clements-Cortes,

2013, p.316). Then, the music therapist matches the music to the client's state of being to give the client a message that they are being heard and understood (Clements-Cortes, 2013). If clients do not participate musically in this type of improvisation, it could also fall under Subcategory one: Receptive music experiences.

Subcategory 4: Compositional music experiences. In compositional music experiences, the client creates a musical product by writing songs, instrumental pieces, or lyrics with the assistance of the music therapist (Bruscia, 2014). In reviewing the literature, I found one compositional music experience that music therapists use to address spiritual issues/needs (as outlined above) in end-of-life care contexts.

Intervention one: Song writing. In song writing, the music therapist assists or supports the client in writing a song that is relevant to his/her life in some way. In end-of-life care contexts, music therapists use songwriting to help clients address feelings of anxiety, worry, and fear. For example, music therapists can work with clients to identify a relevant theme. The music therapist may use a pre-composed song as a springboard for discussion to help identify a theme and/or create lyrics. If the client needs musical assistance, the music therapist may suggest various melodies, song structure, genre, possible harmonic progressions and melodies, and a theme for each verse/chorus (Clements-Cortes, 2013). To facilitate their spiritual/personal connection with others, music therapists can help clients to write "a song of dedication, biographical songs or songs of hopes and wishes for loved ones"(Magill, 2006, p.177). Also, music therapists can assist clients and family members to compose "gift songs" (p.177) to one another for remembrance (Wlodarczyk, 2007). By assisting clients to reflect upon and express aspects of their lives that are meaningful through song writing, music therapists can facilitate the communication between clients and their loved ones (Houck, 2007; Magill, 2006). To restore a sense of hope and faith, music therapists can help clients to create songs with "pertinent statements about themselves, significant others, the world, their faith, their hopes, dreams and/or memories" (Dileo & Magill, 2005, p.232). Moreover, music therapists can assist clients to write a song dedicated to aspects of their spirituality, such as "a song to or for God, a Higher Power, Supreme Being or the universal as identified by the patient" (Dileo & Magill, 2005, p.226). By seeking out information about the role of spirituality in client's life, music therapists can help the client to put this information in a tangible song form structure (Dileo & Magill, 2005).

Category Three: Challenges for Music Therapists

My review of the literature revealed that music therapists do experience a range of challenges when addressing spiritual issues/needs with their clients in end-of-life care. I have organized these into nine emergent subcategories and integrated how they address these challenges into these subcategories when that information was available. The subcategories are not presented in any particular order.

Subcategory one: Difficulty maintaining personal boundaries related to spirituality. When addressing spiritual issues with clients, music therapists must be aware of maintaining appropriate boundaries with regards to their own spiritual beliefs (i.e., one must be respectful of clients' beliefs, particularly when they may contradict or be very different from one's own beliefs). In a study by Barton & Watson (2013) that examined how music therapists' experiences of their spirituality may be relevant to their work, participants said that they usually disclosed limited information about their spiritual beliefs to clients, but it was often difficult to maintain this boundary with end-of-life clients. Some music therapist participants worried that they were crossing boundaries if they prayed for a client or revealed personal spiritual beliefs when clients asked them. In Kidwell's case study (2014), a client asked the music therapist's religion and the therapist revealed her religion but with hesitation. However, when the client suggested that different doctrines within Christianity can be connected through music, the therapist felt more comfortable. Although this case example shows a positive outcome regarding personal self-disclosure, the literature indicates that supervision is essential for music therapists to help monitor this issue. Personal therapy may also be of benefit or even necessary, especially to explore issues and beliefs related to one's one spirituality and how this might be affecting one's work (Barton & Watson, 2013). Having this level of personal insight may help one to achieve a more "authentic religious/agnostic attitude and may avoid/prevent unconscious manipulative tendencies" (Renz, Mao, Omlin, Bueche, Cerny, & Strasser, 2015, p.186). Furthermore, when music therapists are authentically in touch with their own spirituality, they may be better able to support clients with different spiritual viewpoints and used their own spirituality to empathize and respect the client's spirituality (Barton & Watson, 2013). Music therapists should possess or develop their sense of self-awareness, which encompasses their own view of spirituality, and have an open attitude to be in a "journey of discovery, truth, acceptance, hope, and ultimately, loss" (Kidwell, 2014, p.129).

Subcategory two: Lack of clarity around professional boundaries. According to Neudorfer (2016), in music therapy, spirituality is a crucial component in working with end-of-life care clients, but spiritual topics may be avoided due to perceived role conflicts. Although music therapists are not ministers or credentialed spiritual care professionals, they may "act as a link between psychosocial and spiritual needs" (p. 3) and they are bound to address these issues in music therapy contexts should they arise. Kidwell (2014) indicates however, that music therapists should take responsibility to recognize when spiritual care issues go beyond their scope of practice. In a case described by Houck (2007), after the song "All We Get to Heaven" was sung in a music therapy session (at the client's request), he revealed to the music therapist that he was worried that he would not be judged good enough to go to heaven and be reunited with his deceased wife. The music therapist believed he was in "spiritual pain" (p.88) and she requested assistance from the hospice spiritual care provider.

According to Wlodarczyk (2007), in order to provide holistic care, music therapists must try and determine the client's spiritual beliefs and values in the initial assessment. Having at least a basic understanding and openness to what the client shares can help the music therapist and the client to quickly build rapport and also help to avoid assumptions on the part of the therapist. However, the professional boundaries concerning spiritual support and intervention in end-of-life care remain unclear.

Subcategory three: Confrontation with one's own mortality. According to Neudorfer (2016), while providing spiritual care, music therapists not only enter the client's space but also bring in aspects of their own inner life situation and can experience direct confrontation about their own mortality. None of the literature that I reviewed indicated ways in which music therapists are addressing this specific issue in their work but receiving clinical supervision, getting personal therapy, and/or examining one's own beliefs were suggested by several authors as being essential when one is dealing with complex personal responses as a result of his/her professional work (Kidwell, 2014; Magill, 2005; Watson & Barton, 2013).

Subcategory four: Feeling overwhelmed. When addressing spiritual issues in end-of-life care contexts, music therapists can become fatigued and overwhelmed by stress. When this happens, their therapeutic presence can become compromised (Magill, 2005). As a coping strategy, music therapists can utilize self-reflection and self-care practices that explore and nurture their own spiritual beliefs and values. Spending time for "nurturing, healing, supervision,

recreation, and music-making" is recommended (Magill, 2005, p.9). Additionally, Zabin (2005) writes about improvising on the piano or vocalizing while playing percussion instruments at times when she felt feelings of frustration, sadness, and futility, or when she had difficulty accessing her feelings when working with dying patients.

Subcategory five: Dealing with one's own complex emotions. Music therapists can experience a range of complex emotions when addressing spiritual issues with end-of-life care clients. In a case presented by Kidwell (2014), the therapist felt reluctant to play a selection requested by the client ("The 'dying' Swan" by Saint-Saens; the original is actually called "The Swan") as it seemed like the client was expecting this to be his last session and that he was ready to die. The therapist had to recognize the reason for her reluctance and respect the client's request. In a study on music therapists' perspectives on spirituality in practice, the participants emphasized the need to know their own spiritual positions and to reflect upon questions related to life and death outside of sessions. In this way, the therapists felt that they would be able to be fully present for the client rather than being caught up in their own issues (Barton & Watson, 2013).

Lastly, when Potvin (2015) was working with clients and family members in end-of-life care, he experienced countertransference where he strongly identified with his client's emotionally distant husband—eventually realizing that he had had a similar response years earlier when his mother was receiving treatment for breast cancer. In this case, Potvin dealt with his own complex emotional responses by acknowledging them for what they were and using his American Jewish spiritual/cultural background that he shared with the client to facilitate understanding, empathy, and insight into the situation.

Subcategory six: Dealing with clients' complex emotions. Music therapists may experience challenges in dealing with clients' complex emotions, but they need to remain compassionate and present during these times (Magill, 2006). In a case presented by Kidwell (2014), she was concerned about staff's perspectives on a client's challenging behaviour which she perceived as the client experiencing a loss of spiritual well-being whereas others perceived it as a symptom to be addressed through pharmaceutical intervention. Although Kidwell did not feel that other staff would understand what she was doing, Kidwell encouraged the client to express herself outwardly and used the music to reflect the patient's angst and hold her space. This appeared to help the patient to find peace and acceptance. Kidwell had to use empathy and

her own judgement in order to address the client's complex emotions. Squires's (2011) study indicates that music therapists have a role to play with clients who may become distressed when listening to music. When working with very vulnerable clients, music therapy should be implemented with immense sensitivity. "These issues can be addressed through supervision, careful self-reflection, and building trust in the team" (Squires, 2011, p.63).

Lastly, Neudorfer (2016) notes that many end-of-life care clients do not explicitly talk about existential issues. To address these issues, music therapists should possess empathic awareness and knowledge of existential issues to provide solid foundation to clients. With a "stable, caring, and an egalitarian encounter [music therapists can guide the clients in] searching for the sense in life, death, and loss" (p.13).

Subcategory seven: Lack of support from colleagues and/or one's own faith community. Barton and Watson (2013) note that negative impressions of faith communities outnumbered positive opinions of faith communities among three music therapist participants who were interviewed about issues related to spirituality in music therapy practice. Although they recognized that getting support from their own spiritual communities and colleagues could be meaningful at times, they sometimes experienced difficulty engaging in these relationships due to fear of judgment that they thought they might experience by opening up about their own spiritual struggles within the context of this work. However, Clements-Cortes (2013) says that feeling unsupported can make the therapist's work extremely difficult and suggests that music therapists may benefit from "emotional support, guidance and creative programming ideas of fellow music therapists" (p.328). She also suggests that music therapists make connections with colleagues through social networking sites or local organizations.

Subcategory eight: Overuse or misuse of music. Although music therapists may feel a desire to include a lot of music in their sessions, Magill (2005) advises that it is crucial that they not overwhelm the client with music. The client may not have enough strength to deal with the complex emotions or spiritual issues that could be evoked. In these cases, less music or music that is peaceful and unfamiliar, or music that has supportive lyrics may be beneficial. There might be times that music is simply overstimulating and inappropriate, and therapists need to be sensitive to this.

Subcategory nine: Lack of multicultural competence. In end-of-life care, music therapists interact with clients from different cultures/faiths and must use music that is relevant

to that client's culture/faith and understand the role of music within these contexts (Young, 2016). Therefore, deeper exploration of multi-cultural music and other multicultural issues when working with the client's spirituality is crucial and music therapists should be aware of their cultural roles (Squires, 2011). In addition, music therapists need to be prepared to incorporate various healing and spiritual traditions and rituals in music therapy sessions in order to serve a wide population (Dileo & Starr, 2005; Wlodarczyk, 2007). Music therapists can include hymnals or songbooks from the faith communities, and examine the topics of religion and spirituality as well as searching for reliable information from the internet (Wlodarczyk, 2007). This will help music therapists to be sensitive to issues related to diversity and become more effective therapists (Dileo & Starr, 2005). Dileo and Starr (2005) reiterate the importance of music therapists knowing their own spiritual beliefs and cultural heritage and the impact that these things can have on sessions if not well understood by the therapist.

Chapter 4. Discussion

Although music therapists are often called upon to address spiritual needs and issues of clients in end-of-life care, most have limited education and/or training in this subject and few resources exist to help guide them in this area of clinical practice. Furthermore, it is important for music therapists to understand the pertinent ethical and professional boundaries. The purpose of this integrative literature review was to synthesize information contained in the music therapy literature in order to describe how music therapists are addressing spiritual issues in end-of-life care. Twenty-four sources that met the criteria for inclusion were reviewed. Results revealed that music therapists are addressing a range of spiritual needs/issues with their clients in end-of-life care and are using multiple types of interventions to do so. However, the literature also revealed that music therapists experience a number of complex challenges in their work. Although there are some specific and general suggestions on how these challenges may be addressed, the extent to which music therapists are following through on these suggestions is unknown.

The purpose of the present chapter is to highlight positive aspects of the work that is being done by music therapists with regard to how they are addressing their clients' spiritual issues/needs in end-of-life care as well as to identify problems and gaps. Limitations of the study are presented as well as implications of the results for practice, research, and training/education. It is also important to note that after data collection for the current study had been completed, a study entitled Music Therapy and Spiritual Care in End-of-Life: A Qualitative Inquiry into Ethics and Training Issues Identified by Chaplains and Music Therapists (Masko, 2016) was published. Results of my study will be compared and contrasted with relevant findings of Masko's study throughout this chapter so as to make the suggested implications for future research, practice, and education as useful and current as possible.

Reflections on the Results

Results of the present study indicate that music therapists address a range of spiritual needs and issues in end-of-life care and use a range of music experiences to address these needs and issues. All of the literature that I reviewed indicates that music therapists do believe that they have a role to play in addressing the spiritual issues/needs of their clients but that the boundaries of that role are unclear. Furthermore, although there was some overlap in the music experiences used to address these issues/needs, it appears that scope of practice may be defined by individual

music therapists' own knowledge, skill sets, philosophies and also by what is required of them in their particular work contexts. In semi-structured interviews conducted with music therapists and chaplains, Masko (2016) also found that all participants believed that music therapists can address spiritual issues/needs in end-of-life care, as should all members of the multidisciplinary team. Some of the client needs/issues that they identified were similar to those found in my study, such as need for transcendence, enhancing feelings of connection with a higher power, increasing feelings of spiritual comfort, increasing socialization, and anxiety reduction. Other findings in my study that were not directly addressed in Masko's study were: the need to find meaning, the need to restore or affirm one's sense of hope and faith, and the need for resolution or closure. When addressing these needs, it is important to note that good spiritual care means that the music therapist accepts and has insight into his/her own limitations, which helps to define one's own individual scope of practice (Neudorfer, 2016).

Unlike the present study, Masko's study did not examine the music experiences used to address clients' spiritual needs. My study indicated that the widest range of experiences utilized fell within the receptive music experience subcategory (8 different types of interventions) with the other subcategories containing less—3 interventions in the improvisational experience category, 2 interventions in the re-creative music experience category, and 1 intervention in the compositional music experience category. There is no way of knowing, however, how often any particular intervention is used. Additionally, the spiritual issues/needs addressed by particular interventions often overlapped, meaning that no one intervention was used exclusively for any one particular purpose.

Results of the present study confirm that music therapists face a number of challenges when addressing spiritual issues or needs with their clients in end-of-life care.
Similar to Masko's (2016) findings, my findings also indicated that cultural competence was an area of difficulty for music therapists, especially given the wide diversity of clients with whom they work. As in my study, Masko's findings also indicate that therapist self-awareness, especially in terms of knowing one's own cultural values and spiritual beliefs, is essential for music therapists. Their research participants also suggested that therapists must be willing to learn about other cultures. When dealing with clients with different beliefs, Masko's findings suggest that music therapists should accept the client without judgment and be religiously neutral. However, some of the literature that my findings were based on (e.g., Barton & Watson,

2013) suggests that music therapists use their own spirituality to empathize and respect the client's spirituality. I take this to mean that the authors are suggesting that music therapists use their faith to understand clients (without imposing their beliefs) rather than trying to stay religiously neutral in their sessions.

Masko's findings also suggested that chaplains rather than music therapists or other healthcare professionals should handle certain religious rights such as sacramental care. However, in my study's findings, some literature indicates that music therapists be prepared to incorporate various healing and spiritual traditions and rituals in order to serve diverse populations (Dileo & Starr, 2005; Wlodarczyk, 2007). This seems like a complex ethical dilemma that needs further discussion—i.e., what should one do when the spiritual needs of clients cannot be fulfilled—especially when the appropriate person may not be available to do this? This seems likely in some end-of-life care contexts where spiritual representatives/professionals who fall outside of Christian/Judeo faiths may be inaccessible for various reasons. Neudorfer (2016) suggests that music therapists "act as a link between psychosocial and spiritual needs" (p.3). Potvin and Argue (2014) also suggest that music therapists connect clients with the sacred and divine through music. They note that there is an overlap between the concept of ministry and therapy, and music therapists should be aware of the possibility of this overlap and work ethically and effectively. These differences of opinion highlight the need for music therapists to have a more clearly-defined and established scope of practice in end-of-life care.

The findings in my study and Masko's (2016) both suggest that in most cases, music therapists should not to disclose their personal spiritual backgrounds to clients. Masko suggests that an overt display of the therapist's beliefs can lead to spiritual distress and negative experiences for clients. My findings indicate that therapists should seek out supervision, personal therapy, and/or self-awareness practices in order to help maintain appropriate personal boundaries in relation to this issue.

Finally, the findings in my study and Masko's (2016) both suggest that music therapists should limit their scope of practice in spiritual care and only perform duties for which they have received training. However, the boundaries around this area are unclear as the training the music therapists receive in this area is not consistent among training programs.

Results of the present study suggest some problems and gaps in the ways in which music therapists are (or are not) addressing spiritual issues/needs in end-of-life care contexts. Although spirituality is not limited to religious beliefs and practices, when this area was addressed in publications, it was almost always from a Christian-Judeo perspective. It would be helpful if the literature contained more examples from a wider variety of faiths and spiritual practices. Furthermore, spiritual care practices or definitions were not always clearly defined or even labeled as such in the literature. Better definitions and more standardized use of terminology related to spirituality in music therapy might lead to enhanced understanding of the topic.

Additionally, there was a lack of information in the literature on how music therapists currently address issues of spirituality in multidisciplinary team contexts. The chaplain participants in Masko's (2016) study indicated that multidisciplinary hospice health care professionals can cross conventional disciplinary boundaries and that music therapists (and others) can provide spiritual support to clients, but that issues related to role integrity and specific limits around what specific professionals (including music therapists) are able to offer needs to be defined. They suggest that for the time being, music therapists can consult with chaplains and spiritual care coordinators regarding this issue.

Limitations of the Study

This study had some limitations. Although I have worked as a music therapist in end-of-life care settings, this has been limited to academic placements and I have not worked as an employee in this context. Furthermore, this was my first experience of conducting a research project. Additional clinical and research experience may have helped me to further refine and integrate the results. It is also possible that I may have overlooked some publications that should have been included in the data. Furthermore, most of the publications that were included were written by American authors and contextualized within American end-of-life care contexts. Although the results may have relevance for Canadian (and other) music therapists who work in end-of-life care, certain aspects of their work and experiences may not be reflected in the results. It is important to note that after the data had been collected and analyzed, a relevant book entitled Voices of the Dying and Bereaved: Music Therapy Narratives (Clements-Cortes & Varvas Klinck, 2016) was published. Information from this book should be incorporated into a revised version of the current results. As both of these authors are Canadian, this may help to address the previously-noted limitation. Finally, this research only examined published materials and

unpublished dissertations/theses. There may be spiritual issues, interventions, and challenges being experienced and addressed by music therapists that are not contained in these publications but need to be considered nonetheless.

I also made some assumptions, which may have imposed additional limitations on this study. Although I tried to understand and remain open to all faiths, my own Christian beliefs may have inadvertently influenced how I interpreted the results. I also assumed that music therapists do have a role to play in providing spiritual support in end-of-life care but that many music therapists and other professionals are unclear on the parameters of this role.

Implications for Practice

Music therapists who work in end-of-life care have limited resources to guide them in addressing spiritual issues/needs in their practice. I hope that this research will serve as a useful reference and also as a springboard for further discussion and reflection on this topic, which in turn will impact practice.

This study and Masko's (2016) study both indicate the need for music therapists to examine their own cultural, religious, and spiritual backgrounds through personal self-reflection practices as well as through participation in professional supervision. Personal therapy can also help in this endeavor, especially given the psychological and physical demands of this work. A therapist, a supervisor, and/or peer supervision might also provide support or professional empathy that music therapists may not receive from their workplaces. All of these suggestions will in turn, have positive implications for music therapists' practice in end-of-life care contexts––especially as it relates to addressing clients' spiritual needs/issues.

My findings and Masko's (2016) findings suggest that music therapists make referrals to spiritual care practitioners when they feel they are dealing with spiritual issues that fall outside of their scope of practice. Although this may differ from therapist to therapist as the scope of practice in this area is not yet well defined, it is my hope that music therapists will be inspired by this research to make referrals when they feel that it is necessary, consult more often with spiritual practitioners, form more collaborative professional relationships, and become more comfortable with admitting their limitations as well as recognizing their competencies in this area.

Kidwell's case study (2014) and Squires's study (2011) suggested that staff sometimes have misunderstandings about the role of music therapy in addressing distress (including

spiritual distress) in end-of-life care. Increased clinical collaboration could help staff to become more educated about the diverse role of music therapy in end-of-life care contexts and it may also help music therapists to better define their scope of practice, even if it only applies to a particular work context.

Implications for Research

Further research is needed in order to develop a more clearly-defined scope of music therapy practice in end-of-life care and in relation to spiritual practices in particular. This integrative literature review lays the foundation for further work in this area. Further research is needed on how music therapists can effectively and ethically address a wider range of spiritual and faith traditions in their practices. Additional studies that utilize surveys and interviews could help to determine and/or further clarify current issues, practices, and challenges that music therapists are addressing and/or experiencing in end-of-life care contexts in relation to spirituality. A flexible yet clearly defined scope of practice document could be developed from these studies and competencies related to music therapy and spirituality could be established by professional associations and/or music therapy training programs.

While reviewing the literature, I found a limited number of publications related to spiritual care in end-of-life in music therapy. Furthermore, there were few case studies on this topic. I think that we need more case studies because this will provide clinicians with more concrete examples of how music therapists addressed these issues in real life situations. This would at least provide some tangible guidance until a formal scope of practice is established.

Implications for Training/Education

These findings suggest that music therapists need more training and education to understand and work within a wider range of spiritual traditions, not to mention learning the music that is linked with those traditions and the role that the music plays within these traditions (Young, 2016). Ways in which music therapists may receive further education and/or training include: (a) including spiritual care issues as a part of music therapy training curriculums—linked to multicultural topics/courses, (b) receiving feedback/support from a chaplain or spiritual care coordinator—perhaps through having them review personal journals (i.e., process notes) or session reports as Masko (2016) suggests, and (c) participating in spiritual care courses and other relevant continuing education related initiatives that target the specific needs of music therapists.

The CAMT or provincial associations could also increase their continuing education offerings in this area.

My findings indicate that many therapists have challenges in opening up about their own spiritual issues within their own collegial and faith communities due to fear of judgement. We should educate these communities on how to provide more open and supportive environments where therapists feel more comfortable to discuss these issues.

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